Cardell V. Mathis
280 Kenilworth AVE
San Leandro, CA. 94577

IN THE U.S. DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CARDELL VAN MATHIS
Plaintiff

VS

DEPUTY FRELIGH #1818, et. al
Defendants.

NO. C07-3498 WHA

MOTION TO AMEND COMPLAINT FOR ADDITIONAL DEFENDANTS

In the Presiding Court of Judge William Alsup, plaintiff seek to amend complaint by adding Deputy Kidwell, and Deputy Zarham to the complaint. on 12-13-07, Mathis was kept in a holding tank for approximately two days in Alameda County Sheff. DEPT. Booking area. Deputy Zarham and another deputy threaten to kick Mathis, "behind" for the Court) ass and calling Mathis, a bitch! Deputy Griffin, had given Mathis, another bag lunch instead of a hot meal. Mathis, suffered brick and concrete for two days. A week later. Mathis, is called from his housing cell by Deputy Kidwell, telling Mathis, he's being released, right as the dinner meal was being served. Mathis, requested to (~~leave~~) eat first, but was denied by Deputy Kidwell, Mathis, was placed in dress out holding tank in the booking area. Mathis, was given a sweatsuit and no shoes. A deputy told Mathis his clothes hadn't arrived from North County Jail where Mathis was booked on a parole violation PAL warrant. Mathis, was kept in the Dress out tank for another two days. Mathis, was given only bag lunches of bolosnia, that had spoiled. Mathis, spoke loud of the abuse he was suffering

to anyone that would pass by. Deputy Zarham, then, moved Mathis, to another holding cell, and gave Mathis, a bologni bag lunch, after starving him for nearly two days. The bag lunch of bologni, had spoiled, Mathis, found out later when he returned to his cell. The same cell he occupied (8:C:3) approximately 33 hours previously. The cell was assigned to Mathis for the entire silly Charade. Mathis, had to go on an Emergency to the clinic, on 12-22-07 at approximately 0130 hs. Mathis, spoke to LT. White, attempting to explain the events. The LT. ignored Mathis, attempt to explain, telling Mathis to be quiet don't talk. Perhaps for the benefit of the residing nurse. Lieutenant White, nor anyone else did nothing about what happened to Mathis.

When Mathis, was moved to another dress in holding tank, Mathis saw Deputy Griffin, reminding him of the event that had taken place 8 to 9 days earlier. Both middle Eastern looking deputies were present Deputy Zarham, and his Partner. Mathis, reminded them what they said 12-13-07, in another one of the booking tanks. Both men tried to deny it but deputy Griffin remembered. Deputy Zarham, and his Partner, attempted to attack Mathis, Deputy Griffin, wouldn't let them through the door physically using his body to restrain the two from attacking Mathis.

Mathis, was placed on loss of privileges without

NO: C07-3498 WHA

penological justification. NO disciplinary report or a disciplinary hearing. No visiting, No Canteen. or nothing it was as if Mathis, was being reduce to non-existence.

Mathis Petition the court to grant him leave to amend his complaint as to add Lieutenant White, Deputy Zarham, and his not known accomplice to this complaint, and an additional $2,000,000.00 in monetary, punitive, and whatever the court deems fair.

Respectfully Submitted

DATE: 04-24-08

Cardell V. Mathis

Cardell V. Mathis

C.V. Mathis
280 Kentworth Ave
San Leandro, CA. 94577

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CARDELL VAN MATHIS,
Plaintiff,

VS

DEPUTY D. FRELIGH # 1818,
LYNN BOWERS, R.N.

NO. C07-3498 WHA

MOTION FOR ~~APPOINMENT~~ OF COUNSEL.

In the Court of the Honorable presiding Judge, William H. Alsop, Plaintiff, Cardell V. Mathis, request appointment of Counsel. Mathis, says he stated he needed representation in his original filing of his claim to the courts.

Your Honor, Mathis, is currently at this time restricted to the use of a wheelchair, due to chronic back, feet, neck, and shoulder pain. He is classified ADA and (CCCMS) under psychriatric care. Mathis, is also under a highly amount of pain medication and psyche meds., making it highly impossible for him to be able to Prosecute this case, or spell out a claim.

Your Honor, Mathis, motions the court in the interest of Justice for the appointment of Counsel. Enclosed are more supporting documents that supports the essence of granting this motion. EXHIBITS 1-3

Plaintiff Mathis, thanks the Court for its time.

Respectfully Submitted

DATED: 04-22-08

Cardell V. Mathis

Cardell V. Mathis

MEDICAL

EXHIBITS

1-3

1 SANTA RITA CO. JAIL (SRJ) (ALA)

2 San Quentin STATE (SQ) (PR)

3 Deuel VOCATIONAL INST. (DVI)

SRS

DETAIL OFFICE SPECIAL REQUESTS

NAME: _____ DATE: _____

PFN: _____ LOCATION: _____

DOB: _____

1. Move Patient's Location: _____
2. Lower Tier _____ Bottom Bunk _____
3. Linen change: Clothing _____ Bedding _____
4. Crutches _____ Cane _____
5. Other requests: _____

Beginning Date: _____ Ending Date: _____

E. MASTROIANNI, RNP
_____
Signature

SRJ-105 (10/03) PD 351 (Rev. 10/03) Santa Rita Jail / Glenn Dyer

NAME: _____ DATE: _____

PFN: _____ LOCATION: _____

DOB: _____

2. Move Patient's Location: _____
2. Lower Tier _____ Bottom Bunk _____
3. Linen change: Clothing _____ Bedding _____
4. Crutches _____ Cane _____
6. Other requests: _____

Beginning Date: _____ Ending Date: _____

_____
Signature

SRJ-105 (10/03) PD 351 (Rev. 10/03) Santa Rita Jail / Glenn Dyer

SRJ

Prison Health Services Medical Request Form

- *Inmate – do not write in shaded area.*
- *Place this form in the sick call box or give it to medical staff.*
- *If you do not complete all of the information, your appointment may be delayed.*
- *A copy will be given to you after the visit.*
- *You may be charged $3.00 for each health care visit.*

DATE OF REQUEST	LAST NAME	FIRST NAME	MIDDLE NAME	PFN
1-02-07	Martin	Cordell	Von	AM[illegible]

HOUSING LOCATION

SRJ – UNIT#_____ POD_____ CELL_____ GDDF – FLOOR_____ POD_____ CELL_____

CO-PAYMENT INFORMATION – TO BE FILLED OUT BY DEPARTMENTAL STAFF

1. _____ Patient not seen: _____ NIC _____ DUPLICATE _____ NO SHOW _____ REFUSED _____ OTA
2. _____ Visit was for diagnosis or treatment of communicable disease condition.
3. _____ Visit was for a follow-up requested by the clinician.
4. _____ Visit was NOT exempt from co-payment – Send ORIGINAL copy to Accounting.

CLINICIAN'S SIGNATURE	CLINICIAN'S NAME (Print/Stamp)	DATE

Inmate's Signature	_____ Patient Refused to Sign	Witness If Patient Refused to Sign
[signature]		

Date of Triage:_____ Nurse Signature and Print/Stamp_____

Disposition: ☐Sick Call _____ ☐Specialty Clinic _____ ☐Other_____

RELEASE OF RESPONSIBILITY

I am refusing sick call due to: _____

Date: _____ Inmate's Signature: _____ _____ Refused to Sign

CLINICIAN'S SIGNATURE	CLINICIAN'S NAME (Print/Stamp)	Witness if Patient Refused to Sign

Tell us below why you want to see health care staff. In the area below, write down anything you want health care staff to know.

I need a cream for soreness. I've been waiting for the results of the blood test so I can get the prescription for the Valtrex. This is a follow up

Signature of Inmate Patient [signature] Date of Signature 01-02-07

ORIGINAL: Accounting PINK: Health Services File CANARY: Inmate/Patient Revised 7/06

SRJ

Prison Health Services Medical Request Form

- *Inmate – do not write in shaded area.*
- *Place this form in the sick call box or give it to medical staff.*
- *If you do not complete all of the information, your appointment may be delayed.*
- *A copy will be given to you after the visit.*
- *You may be charged $3.00 for each health care visit.*

DATE OF REQUEST	LAST NAME	FIRST NAME	MIDDLE NAME	PFN
2-9-08	Mathis	Cardell	Van	AMP-834

HOUSING LOCATION

SRJ – UNIT# 8V POD B CELL 5 GDDF – FLOOR _____ POD _____ CELL _____

CO-PAYMENT INFORMATION – TO BE FILLED OUT BY DEPARTMENTAL STAFF

1. _____ Patient not seen: _____NIC _____DUPLICATE _____NO SHOW _____REFUSED _____OTA
2. _____ Visit was for diagnosis or treatment of communicable disease condition.
3. _____ Visit was for a follow-up requested by the clinician.
4. _____ Visit was NOT exempt from co-payment. Send ORIGINAL copy to Accounting.

CLINICIAN'S SIGNATURE	CLINICIAN'S NAME (Print/Stamp)	DATE
Cardell V. Mathis		
Inmate's Signature	Patient Refused to Sign	Witness if Patient Refused to Sign

Date of Triage: _____ Nurse Signature and Print/Stamp _____

Disposition: ☐Sick Call ☐Specialty Clinic ☐Other

RELEASE OF RESPONSIBILITY

I am refusing sick call due to: _____

Date: _____ Inmate's Signature: _____ _____ Refused to Sign

CLINICIAN'S SIGNATURE	CLINICIAN'S NAME (Print/Stamp)	Witness if Patient Refused to Sign

Tell us below why you want to see health care staff. In the area below, write down anything you want health care staff to know.

I am requesting, "pleading", that I be given a refill for my exhausted ~~Sub~~ Prescription of Vikadin. An increase in dosage is essentially pertinent for my increasing pain, in my ~~feet~~ and back.

Signature of Inmate Patient Cardell Van Mathis Date of Signature 02-09-08

ORIGINAL: Accounting PINK: Health Services File CANARY: Inmate/Patient Revised 7/06

1(c)

SQ

STATE OF CALIFORNIA DEPARTMENT OF CORRECTIONS

COMPREHENSIVE ACCOMMODATION CHRONO

INSTRUCTIONS: A physician shall complete this form if an inmate requires an accommodation due to a medical condition. Circle P if the accommodation is to be permanent, or T if the accommodation is to be temporary. If the accommodation is temporary, write the date the accommodation expires on the line. A new form shall be generated when a change to an accommodation is required or upon renewal of a temporary accommodation. Any new form generated shall include previous accommodations, if they still apply. Chronos indicating permanent accommodations shall be reviewed annually. This form shall be honored as a permanent chrono at all institutions.

A. HOUSING

None

1. Barrier Free/Wheelchair Access P / T _____
2. Ground Floor Cell (P) / T _____
3. Continuous Powered Generator P / T _____
4. Bottom Bunk (P) / T _____
5. Single Cell (See 128-C date: _____) P / T _____
6. Permanent OHU / CTC (circle one) P / T _____
7. Other _____ P / T _____

B. MEDICAL EQUIPMENT/SUPPLIES

None

8. Limb Prosthesis P / T _____
9. Brace P / T _____
10. Crutches P / T _____
11. Cane: (type) Wood (P) / T _____
12. Walker P / T _____
13. Dressing/Catheter/Colostomy Supplies P / T _____
14. Shoe: (specify) _____ P / T _____
15. Dialysis Peritoneal P / T _____
16. Wheelchair: (type) _____ P / T _____
17. Contact Lens(es) & Supplies P / T _____
18. Hearing Aid P / T _____
19. Special Garment: (specify) _____ P / T _____
20. Rx. Glasses: _____ P / T _____
21. Cotton Bedding P / T _____
22. Extra Mattress (P) / T _____
23. Other _____ P / T _____

C. OTHER

None

24. Attendant to assist with meal access and other movement inside the institution. P / T _____

Attendant will not feed or lift the inmate/patient or perform elements of personal hygiene.

25. Wheelchair Accessible Table P / T _____
26. Therapeutic Diet: (specify) P / T _____
27. Communication Assistance P / T _____
28. Transport Vehicle with Lift P / T _____
29. Short Beard P / T _____
30. Other _____ P / T _____

D. PHYSICAL LIMITATIONS TO JOB ASSIGNMENTS

Based on the above, are there any physical limitations to job assignments? ☒ Yes ☐ No

If yes, specify: Disabled

INSTITUTION: SQ	COMPLETED BY (PRINT NAME): ALVAREZ	TITLE: MD
SIGNATURE:	DATE: 2/20/8	CDC NUMBER, NAME (LAST, FIRST, MI) AND DATE OF BIRTH: MATHIS E21981 7/6/57
HCM/CMO SIGNATURE	DATE	
APPROVED (list the number of items approved)		
DENIED (list the number of items denied)		

COMPREHENSIVE ACCOMMODATION CHRONO

2(a)

STATE OF CALIFORNIA
DISABILITY PLACEMENT PROGRAM VERIFICATION (DPPV)
CDC 1845 (Rev. 01/04)

DEPARTMENT OF CORRECTIONS
CHECK ALL APPLICABLE BOXES

THIS FORM ONLY VERIFIES OR DISCONFIRMS CLAIMED PHYSICAL DISABILITIES LISTED IN SECTION B

INMATE NAME:	CDC NUMBER:	INSTITUTION:	HOUSING ASSIGNMENT:	DATE FORM INITIATED:

Sections A - B to be completed by licensed medical staff.

SECTION A: REASON FOR INITIATION OF FORM

- [x] Inmate self-identifies to staff
- [ ] Third party evaluation request
- [x] Observation by staff
- [ ] Medical documentation or Central File information

SECTION B: DISABILITY BEING EVALUATED

- [ ] Blind/Vision Impaired
- [ ] Speech Impaired
- [ ] Deaf/Hearing Impaired
- [x] Mobility Impaired

Sections C - G to be completed by a physician only.

SECTION C: PERMANENT DISABILITIES IMPACTING PLACEMENT

1. [ ] FULL TIME WHEELCHAIR USER - **DPW**
Requires wheelchair accessible housing and path of travel.

2. [ ] INTERMITTENT WHEELCHAIR USER - **DPO**
Requires lower bunk, wheelchair accessible path of travel and ***does not require*** wheelchair accessible cell.

3. [x] MOBILITY IMPAIRMENT - With or Without Assistive Device (Wheelchairs shall not be prescribed) - **DPM**
Orthopedic, neurological or medical condition that substantially limits ambulation (cannot walk 100 yards on a level surface without pause). Requires lower bunk, no triple bunk, and no stairs in path of travel.

4. [ ] DEAF/HEARING IMPAIRMENT - **DPH**
Must rely on written communication, lip reading or signing as residual hearing, with assistive devices, will not enable them to hear, understand or localize emergency warnings or public address announcements.

5. [ ] BLIND/VISION IMPAIRMENT - **DPV**
Not correctable to central vision acuity of better than 20/200 with corrective lenses in at least one eye (See HOUSING RESTRICTIONS IN SECTION E).

6. [ ] SPEECH IMPAIRMENT - **DPS**
Does not communicate effectively speaking or in writing.

SECTION D: PERMANENT DISABILITIES *NOT* IMPACTING PLACEMENT

1. NO CORRESPONDING CATEGORY

2. NO CORRESPONDING CATEGORY

3. [ ] MOBILITY IMPAIRMENT (Lower Extremities) - **DNM**
Walks 100 yards without pause with or without assistive devices.
- [ ] No Housing Restrictions
- [ ] See HOUSING RESTRICTIONS in Section E
- [ ] Requires relatively level terrain and no obstructions in path of travel. **Do not place at:** CCI, CMC-E, CRC, CTF-C, FSP, SCC I or II, SOL, or SQ. (CDC 128-C:_____)

4. [ ] HEARING IMPAIRMENT - **DNH**
With residual hearing at a functional level with hearing aid(s).

5. NO CORRESPONDING CATEGORY

6. [ ] SPEECH IMPAIRMENT - **DNS**
Does not communicate effectively speaking, but does when writing.

SECTION E: ADDITIONAL MEDICAL INFORMATION

CSR ALERT:
- [x] Requires relatively level terrain and no obstructions in path of travel
- [ ] Complex medical needs affecting placement
- [x] CDC 128-C _____

HEALTH CARE APPLIANCE / IDENTIFICATION VEST:
- [x] Cane
- [ ] Crutch
- [ ] Walker
- [ ] Leg/Arm prosthesis
- [ ] Vest
- [ ] Other: _____
- [ ] CDC 128-C(s) dated: _____

ASSISTANCE NEEDED WITH ACTIVITIES OF DAILY LIVING:
- [ ] Feeding or Eating
- [ ] Bathing
- [ ] Grooming
- [ ] W/C transferring
- [ ] Toileting
- [ ] Other: _____
- [ ] CDC 128-C(s) dated: _____

OTHER DPP DESIGNATIONS:
- [ ] **NONE**

CODE	DATED	CODE	DATED

HOUSING RESTRICTIONS: [ ] Lower bunk [ ] No stairs [ ] No triple bunk. CDC 128-C(s) dated: _____

SECTION F: EXCLUSIONS

- [ ] VERIFICATION OF CLAIMED DISABILITY NOT CONFIRMED: My physical examination or other objective data DOES NOT SUPPORT ***claimed*** disability. (Explain in Comments Section and CDC 128-C dated _____).
- [ ] REMOVAL FROM A DPP CODE: Removal from previous DPP code: _____. (Explain in Comments Section and CDC 128-C dated: _____.)
- [ ] REMOVAL FROM ENTIRE PROGRAM: Removal from DPP code(s): _____. (Explain in Comments Section and CDC 128-C dated: _____.)

SECTION G: EFFECTIVE COMMUNICATION FACTORS

- [ ] Uses Sign Language Interpreter (SLI)
- [ ] Reads Braille
- [ ] Communicates with written notes
- [ ] Requires large print or magnifier
- [ ] Reads lips
- [x] NO "EFFECTIVE COMMUNICATION" ISSUES OBSERVED OR DOCUMENTED IN THE UNIT HEALTH RECORD

PHYSICIAN'S COMMENTS: *(Focus on affected systems and functional limitations. No specific diagnosis or other confidential medical information.)*

PHYSICIAN'S NAME (Print)	PHYSICIAN'S SIGNATURE	DATE SIGNED
HEALTH CARE MANAGER'S / DESIGNEE'S NAME (Print)	HEALTH CARE MANAGER'S / DESIGNEE'S SIGNATURE	DATE SIGNED

NOTE: After review by the Health Care Manager or Chief P[illegible]ian & Surgeon, health care staff shall retain green copy for the UHR, send the inmate copy via institutional and route the original and remaining copies to the C&PR/RC[illegible]r tracking and further distribution according to the instructions below.

STATE OF CALIFORNIA
DISABILITY PLACEMENT PROGRAM VERIFICATION (DPPV)
CDC 1845 (Rev. 01/04)

DEPARTMENT OF CORRECTIONS
CHECK ALL APPLICABLE BOXES

3(a)1

THIS FORM ONLY VERIFIES OR DISCONFIRMS CLAIMED PHYSICAL DISABILITIES LISTED IN SECTION B

INMATE NAME:	CDC NUMBER:	INSTITUTION:	HOUSING ASSIGNMENT:	DATE FORM INITIATED:
Mathis	E21951			

Sections A - B to be completed by licensed medical staff.

SECTION A: REASON FOR INITIATION OF FORM

- [X] Inmate self-identifies to staff
- [ ] Third party evaluation request
- [X] Observation by staff
- [ ] Medical documentation or Central File information

SECTION B: DISABILITY BEING EVALUATED

- [ ] Blind/Vision Impaired
- [ ] Speech Impaired
- [ ] Deaf/Hearing Impaired
- [X] Mobility Impaired

Sections C - G to be completed by a physician only.

SECTION C: PERMANENT DISABILITIES IMPACTING PLACEMENT

1. [ ] FULL TIME WHEELCHAIR USER - **DPW**
   Requires wheelchair accessible housing and path of travel.
2. [X] INTERMITTENT WHEELCHAIR USER - **DPO**
   Requires lower bunk, wheelchair accessible path of travel and ***does not require*** wheelchair accessible cell.
3. [ ] MOBILITY IMPAIRMENT - With or Without Assistive Device (Wheelchairs shall not be prescribed) - **DPM**
   Orthopedic, neurological or medical condition that substantially limits ambulation (cannot walk 100 yards on a level surface without pause). Requires lower bunk, no triple bunk, and no stairs in path of travel.
4. [ ] DEAF/HEARING IMPAIRMENT - **DPH**
   Must rely on written communication, lip reading or signing as residual hearing, with assistive devices, will not enable them to hear, understand or localize emergency warnings or public address announcements.
5. [ ] BLIND/VISION IMPAIRMENT - **DPV**
   Not correctable to central vision acuity of better than 20/200 with corrective lenses in at least one eye (See HOUSING RESTRICTIONS IN SECTION E).
6. [ ] SPEECH IMPAIRMENT - **DPS**
   Does not communicate effectively speaking or in writing.

SECTION D: PERMANENT DISABILITIES *NOT* IMPACTING PLACEMENT

1. NO CORRESPONDING CATEGORY
2. NO CORRESPONDING CATEGORY
3. [ ] MOBILITY IMPAIRMENT (Lower Extremities) - **DNM**
   Walks 100 yards without pause with or without assistive devices.
   - [ ] No Housing Restrictions
   - [ ] See HOUSING **RESTRICTIONS** in Section E
   - [ ] Requires relatively level terrain and no obstructions in path of travel. **Do not place at:** CCI, CMC-E, CRC, CTF-C, FSP, SAC, SCC I or II, SOL, or SQ. (CDC 128-C:_____)
4. [ ] HEARING IMPAIRMENT - **DNH**
   With residual hearing at a functional level with hearing aid(s).
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CSR ALERT:
- [X] Requires relatively level terrain and no obstructions in path of travel
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HEALTH CARE APPLIANCE / IDENTIFICATION VEST:
- [X] Cane
- [ ] Crutch
- [ ] Walker
- [ ] Leg/Arm prosthesis
- [ ] Vest
- [X] Other: _____
- [ ] CDC 128-C(s) dated: _____

ASSISTANCE NEEDED WITH ACTIVITIES OF DAILY LIVING:
- [ ] Feeding or Eating
- [ ] Bathing
- [ ] Grooming
- [ ] W/C transferring
- [ ] Toileting
- [ ] Other: _____
- [ ] CDC 128-C(s) dated: _____

OTHER DPP DESIGNATIONS:
- [ ] **NONE**

CODE	DATED	CODE	DATED
_____	_____	_____	_____

HOUSING RESTRICTIONS: [X] Lower bunk [ ] No stairs [X] No triple bunk. CDC 128-C(s) dated: _____

SECTION F: EXCLUSIONS

- [ ] VERFICATION OF CLAIMED DISABILITY NOT CONFIRMED: My physical examination or other objective data DOES NOT SUPPORT ***claimed*** disability. (Explain in Comments Section and CDC 128-C dated _____).
- [X] REMOVAL FROM A DPP CODE: Removal from previous DPP code: 1 1 M. (Explain in Comments Section and CDC 128-C dated: 2/12/08.)
- [ ] REMOVAL FROM ENTIRE PROGRAM: Removal from DPP code(s): _____. (Explain in Comments Section and CDC 128-C dated: _____.)

SECTION G: EFFECTIVE COMMUNICATION FACTORS

- [ ] Uses Sign Language Interpreter (SLI)
- [ ] Reads Braille
- [ ] Communicates with written notes
- [ ] Requires large print or magnifier
- [ ] Reads lips
- [X] NO "EFFECTIVE COMMUNICATION" ISSUES OBSERVED OR DOCUMENTED IN THE UNIT HEALTH RECORD

PHYSICIAN'S COMMENTS: *(Focus on affected systems and functional limitations. No specific diagnosis or other confidential medical information.)*

PHYSICIAN'S NAME (Print)	PHYSICIAN'S SIGNATURE	DATE SIGNED
HEALTH CARE MANAGER'S / DESIGNEE'S NAME (Print)	HEALTH CARE MANAGER'S / DESIGNEE'S SIGNATURE	DATE SIGNED

NOTE: After review by the Health Care Manager or Chief Physician & Surgeon, health care staff shall retain green copy for the UHR, send the inmate copy via institutional mail, and route the original and remaining copies to the C&PR/RC CC-III for tracking and further distribution according to the instructions below.

DISTRIBUTION: **Original** - Top General Chrono Section of C-File; **Green** - Chrono Section, Unit Health Record **Canary** - C&PR/CC-III; **Pink**-CC-I; **Gold**-Inmate

DVI
3 (a) 2

ALIFORNIA

DEPARTMENT OF CORRECTIONS

COMPREHENSIVE ACCOMMODATION CHRONO

INSTRUCTIONS: A physician shall complete this form if an inmate requires an accommodation due to a medical condition. Circle P if the accommodation is to be permanent, or T if the accommodation is to be temporary. If the accommodation is temporary, write the date the accommodation expires on the line. A new form shall be generated when a change to an accommodation is required or upon renewal of a temporary accommodation. Any new form generated shall include previous accommodations, if they still apply. Chronos indicating permanent accommodations shall be reviewed annually. This form shall be honored as a permanent chrono at all institutions.

A. HOUSING

None		Bottom Bunk	P / T
Barrier Free/Wheelchair Access	P / T	Single Cell (See 128-C date:)	P / T
Ground Floor Cell	P / T	Permanent OHU / CTC (circle one)	P / T
Continuous Powered Generator	P / T	Other	P / T

B. MEDICAL EQUIPMENT/SUPPLIES

None		Wheelchair: (type)	P / T
Limb Prosthesis	P / T	Contact Lens(es) & Supplies	P / T
Brace	P / T	Hearing Aid	P / T
Crutches	P / T	Special Garment:	
Cane: (type)	P / T	(specify)	P / T
Walker	P / T	Rx. Glasses:	P / T
Dressing/Catheter/Colostomy Supplies	P / T	Cotton Bedding	P / T
Shoe: (specify)	P / T	Extra Mattress	P / T
Dialysis Peritoneal	P / T	Other	P / T

C. OTHER

None		Therapeutic Diet: (specify)	P / T
Attendant to assist with meal access and other movement inside the institution.	P / T		
Attendant will not feed or lift the inmate/patient or perform elements of personal hygiene.		Communication Assistance	P / T
		Transport Vehicle with Lift	P / T
		Short Beard	P / T
Wheelchair Accessible Table	P / T	Other	P / T

D. PHYSICAL LIMITATIONS TO JOB ASSIGNMENTS

Based on the above, are there any physical limitations to job assignments? ☐ Yes ☐ No

If yes, specify:

INSTITUTION	COMPLETED BY (PRINT NAME)	TITLE
SIGNATURE	DATE	CDC NUMBER, NAME (LAST, FIRST, MI) AND DATE OF BIRTH
HCM/CMO SIGNATURE	DATE	
(CIRCLE ONE) APPROVED / DENIED		

COMPREHENSIVE ACCOMMODATION CHRONO

3 (a)

Distribution:
Original - Unit Health Record Canary - Central File Pink - Correctional Counselor Gold - Inmate

CDC 7410 (03/04)

DVT 3(b)1

Department of Corrections and Rehabilitation *Date Printed: 3/17/2008 12:03 PM*

Inmate History

Deuel Vocational Institution

Inmate Name: **MATHIS, CARDELL**

CDC Number: **E21981** Housing: **WCT1RC000000007L** Arrival Date: **2/26/2008** From: **SQ**

CM: Current Status: **3/17/2008 Current MH Inmate** GAF: **70**

Primary Psychiatrist: Care Level: **CCCMS** Last CM: **2/27/2008** 7386-MH: **12/14/2006**

Last Psy: **3/5/2008** Last IDTT 7387-MH:

Axis I.1: **303.90 - Alcohol Dependence**

Behavior Alerts:

Appointment History:

Date	Staff	Reason for Visit	Comment
3/5/2008	A. Coppola, M.D.	Lab Work	APPT COMP
2/27/2008	X. Zhou, M.D.	Med Renewal Psych	APPT COMP
2/27/2008	X. Zhou, M.D.	Doc/Undoc Meds-M.D.	APPT COMP
2/27/2008	J. Eshom, Psy.D.	Doc/Undoc Meds-CCM	APPT COMP
2/27/2008	J. Eshom, Psy.D.	Screening Positive	APPT COMP
7/5/2007	C. Anderson, Psy.D.	Screening Negative	APPT COMP
12/14/2006	C. Nyamora, Psy.D.	Further Eval CM	APPT COMP
12/5/2006	C. Anderson, Psy.D.	Screening Positive	APPT COMP

Missed Appointment History:

Date	Staff	Reason for Visit	Comment
12/22/2006	C. Nyamora, Psy.D.	Referral Self CM	REFUSED

Referral History:

Referral Date	Referred By	Resulting Action	Rejection from Program Reason (if applicable)
12/20/06 (0:00)	Self	Referred to Case Manager	

MHCB Stay History:

Admit Date	Clinical Discharge Date	Physical Move Out Date	Length (days) Clinical Stay	Length (days) Physical Stay	Reason for MHCB Stay

OHU Placement History:

Placement Date	Clear for Removal Date	Physical Move Out Date	Length (hrs) of Placement	Length (hrs) of OHU Stay	Reason for OHU Stay

Suicide Eval/SRAC History

Eval Date/Time	Risk Factor	SRAC Date/Time	Reason forSRAC
12/14/2006 00:00	1		

Full Prescription History:

Medication	Physician	Start Date	Stop Date	Last Pharmacy Import Date
SIG 1	SIG 2			
ARIPIPRAZOLE 5MG	ZHOU, XIAOYIN	2/27/2008	4/12/2008	3/17/2008
TAKE 1 TAB EVERY EVENING	========PM========**DOT**			ARIPIPRAZOLE

Key for AXIS: (P) = Provisional diagnosis (R) = Rule out diagnosis

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DVT
362

Department of Corrections and Rehabilitation *Date Printed: 3/17/2008 12:03 PM*

Inmate History

Deuel Vocational Institution

3

Inmate Name: **MATHIS, CARDELL**

CDC Number: **E21981** Housing: **WCT1RC000000007L** Arrival Date: **2/26/2008** From: **SQ**

HYDROXYZINE 25MG TABLET TAKE 4 TABS EVERY EVENING	ZHOU, XIAOYIN =======PM========**DOT**=	2/27/2008	4/12/2008	3/17/2008 VISTARIL 25MG TABLET
MIRTAZAPINE 30MG TAKE 1 TAB EVERY EVENING	ZHOU, XIAOYIN ========PM========**DOT**	2/27/2008	4/12/2008	3/17/2008 MIRTAZAPINE
ACETAMINOPHEN W/COD 30MG TAKE 1 TABLET TWICE A DAY	FOX, MICHAEL D. CRUSH & ADD IN LIQUID*DOT	2/27/2008	3/28/2008	3/17/2008 CODEINE
ACETAMINOPHEN 325MG #24 TAKE 2 TABS ORALLY TWICE	FOX, MICHAEL D. DAILY*KOP*REFILLS X2	2/27/2008	3/28/2008	3/17/2008 TYLENOL
ARIPIPRAZOLE 5MG TAKE 1 TAB EVERY EVENING	ZHOU, XIAOYIN ========PM========**DOT**	2/27/2008	3/13/2008	3/17/2008 ARIPIPRAZOLE
HYDROXYZINE 50MG TABLET TAKE 2 TABS EVERY EVENING	ZHOU, XIAOYIN =======PM========**DOT**=	2/27/2008	3/13/2008	3/17/2008 VISTARIL 50MG TABLET
MIRTAZAPINE 30MG TAKE 1 TAB EVERY EVENING	ZHOU, XIAOYIN ========PM========**DOT**	2/27/2008	3/13/2008	3/17/2008 MIRTAZAPINE
ACETAMINOPHEN W/COD 30MG TAKE 1 TABLET TWICE A DAY	FOX, MICHAEL D. CRUSH & ADD IN LIQUID*DOT	2/27/2008	3/10/2008	3/17/2008 CODEINE
DC'd HYDROXYZINE CAP 50MG TAKE 2 TABS EVERY EVENING	FOX, MICHAEL D. =======PM========**DOT**=	2/27/2008	2/27/2008	3/17/2008 HYDROXYZINE *DC
DC'd MIRTAZAPINE 30MG TAKE 1 TAB EVERY EVENING	FOX, MICHAEL D. ========PM========**DOT**	2/27/2008	2/27/2008	3/17/2008 MIRTAZAPINE *DC
ACETAMINOPHEN 325MG TAKE 2 TABS 3 TIMES DAILY	NEWMAN, HARRY REFILLS X1	12/19/2006	1/9/2007	12/20/2006 TYLENOL

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362